# MONUMENT PHYSICAL THERAPY


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## PHYSICAL / OCCUPATIONAL THERAPY REFERRAL

Patient's Name ______________________________ Date of Birth ____________

Address ______________________________ Phone Number ____________________

Diagnosis ______________________________________________

Referring Physician ______________________________ Code ________________

Onset Date __________________________ Patient Aware of Dx ✓ yes ____ no

**TREATMENT DESIRED**

X Evaluate and Treat

X Modalities

- X Hot/Cold Pack
- X Ultrasound/Phonophoresis
- X Electrical Stimulation
- X TENS
- X Iontophoresis
- _____ Parafin

X Traction

_____ Pelvic Rehabilitation

X Therapeutic Exercise

- X AROM
- X PROM
- X Strengthening
- X Stretching
- _____ Pool
- _____ Gait Training
- _____ Lifting/Posture Instruction

X Home Exercise Program

X Manual Therapy

- X Soft Tissue
- X Joint Mobilization
- _____ Other

_____ Hand Program

_____ Splint/Orthotic Fabrication

_____ Functional Capacity Evaluation

_____ Work Site Evaluation

_____ Work Hardening/Conditioning

_____ Patient care has been discontinued

Special Instructions PER PLAN CARE

______________________________________________

Frequency 2-3X/WEEK Duration 4 WEEKS

Goals INCREASE ROM & STRENGTH, DECREASE PAIN & SWELLING, AND IMPROVE FUNCTION

Precautions ______________________________________________

Date ______________________ Signature **X** ______________________